IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, et al.,
Petitioners,
v.
ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, et al.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR AMICUS CURIAE PHARMACISTS GUILD OF MICHIGAN

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This brief is filed on behalf of the Pharmacists Guild of Michigan with the written consent of all parties to this proceeding pursuant to Rule 42 of the Court.

THE INTEREST OF THE AMICUS CURIAE

The Pharmacists Guild of Michigan (Pharmacists Guild) is a voluntary, nonprofit membership association composed of approximately 250 small independent pharmacists located throughout the State of Michigan. Most of its members are faced with doing business under a prepaid prescription plan substantially identical to the one condemned by the Fifth Circuit Court of Appeals in the instant controversy.

The Fifth Circuit Court of Appeals has held that price fixing in a prescription plan does not constitute the "business of insurance" and does not focus on the relationship between the insurer and the policyholder. Price fixing, regardless of its context, is a per se violation of Section 1 of the Sherman Act, 15 U.S.C. § 1 (1970).

The Pharmacists Guild is vitally interested in fostering a free and open, competitive pharmaceutical market. The price fixing and boycott activities of Petitioners herein, if protected from antitrust scrutiny, would drive the small, service oriented independent pharmacist out of business in Texas, a result not contemplated or intended by the authors of the McCarran-Ferguson Act. The public would otherwise be faced with having to accept the prices of pharmaceuticals dictated by the few large pharmacy chains. The small independent pharmacist in Michigan is faced with substantially identical price fixing and boycott activities and accordingly has a personal interest in the outcome of this litigation.

SUMMARY OF ARGUMENT

Petitioners herein are seeking to exempt their price fixing and boycott activities from antitrust review by virtue of the McCarran-Ferguson Act (hereinafter referred to as the "McCarran Act"). The Courts have held that the McCarran Act must be strictly construed, and the Petitioners in seeking its application have the burden of demonstrating that the activities at issue (a) are in the "business of insurance" and (b) are regulated by "State law". Petitioners have failed to meet this burden. The McCarran Act has no application in this case.

The courts have defined the "business of insurance" concept narrowly, holding that it only applies to activities which are *peculiar* to the insurance industry and actions which primarily involve the relationship between the insurance company and its policyholders. The price fixing and boycott activities of Petitioners are not peculiar to the insurance industry. Nor do the challenged activities of Petitioners involve the relationship between Petitioner Blue Shield and its policyholders. The price fixing and coercion herein primarily involve relationships between competing pharmacies and between pharmacies and their customers. Petitioner Blue Shield's *sole obligation* to its policyholders is to supply pharmaceuticals and to ensure that its subscribers pay no more than the drug deductible. So long as policyholders only pay the drug deductible, they are basically unconcerned with arrangements made between Blue Shield and the pharmacies.

Petitioners' argument that the "type of policy", its feature of providing "goods and services benefits" instead of cash indemnification, and its purpose to contain claims costs, is not available. This argument does not transform Petitioners' price fixing and boycott activities into the "business of insurance". The "goods and services benefit" herein is the providing of pharmaceuticals and *not* the fixing of their prices. Furthermore Blue Shield's alleged purpose to contain claims costs does not make the challenged activities the "business of insurance". The Congress and the courts have consistently held for decades that price fixing is a per se violation of the Sherman Act, regardless of its reasonableness or noble purpose.

Any argument that the challenged activities of Petitioners constitute the "business of insurance" because they lower rates which in turn have a favorable impact on Blue Shield's "status as a reliable insurer" must also fail. Any activity which increases the profits of an insurance company enhances its reliability and solvency. As this Court found in *SEC* v *National Securities, Inc.*, 393 U.S. 453 (1969), the mere fact that an activity makes an insurance company more financially reliable does not dictate that such activity constitutes the "business of insurance".

Petitioners have also failed to show that their challenged activities are regulated by *State law*. Their price fixing and boycott actions clearly were not regulated by Texas law. Petitioners argue that a plan "identical" in concept to the plan at issue herein was approved by the Attorney General for the State of Texas in 1962. Approval by the State Attorney General cannot amount to regulation by *State law*. In any event the plan

approved by the Attorney General did not contain any price fix or boycott mechanisms. The Attorney General approval only covered the mechanics and administration of the plan.

It is also clear from the record in this case that the Texas State Board of Insurance *did not* approve the Pharmacy Agreement at issue. On deposition, a responsible official from the State Board of Insurance stated that the agreement was not within the regulatory control of the State Board. This fact that the State of Texas has declared that the Pharmacy Agreement is outside its regulatory control is significant, because it uncontestably demonstrates that there is *no conflict* between state insurance regulation and federal antitrust enforcement in this case. A primary purpose behind the passage of the McCarran Act was to preserve from federal interference the state's traditional role of regulating the "business of insurance". As conceded by the State of Texas, there is no State regulation to protect in this case. The McCarran Act accordingly has no application herein.

For these reasons, and for the reasons set forth in detail herein, the judgment of the Fifth Circuit Court of Appeals should be affirmed.

ARGUMENT

Introduction

Petitioners ask the Court to find that certain activities are immunized from antitrust scrutiny by virtue of the McCarran Act. That Act provides a statutory exemption to actions which would normally be subject to antitrust

liability. Statutes like the McCarran Act "are to be construed strictly". *Abbott Labs.* v *Portland Retail Druggists Ass'n., Inc.*, 425 U.S. 1, 11 (1976). Any laxity in finding exemptions from antitrust laws has been rebuked by this Court with the observation that " '[O]ur cases have repeatedly established . . . a heavy presumption against implicit [antitrust] exemptions.' " *Abbott Labs.* v *Portland Retail Druggists Ass'n., Inc.*, 425 U.S. 1, 12 (1976) (brackets in original), quoting *Goldfarb* v *Virginia State Bar*, 421 U.S. 773, 787 (1975). Those who would invoke the McCarran Act exemption accordingly shoulder a heavy burden of clearly demonstrating its application.

The McCarran Act is narrow in scope. Only actions or activities in the "business of insurance" that are regulated by State law attain exempt status. Section 2(b) of the Act provides:

> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, . . . unless such Act specifically relates to the business of insurance: *Provided*, That . . . the Sherman Act, . . . the Clayton Act, and . . . the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by *State law*. (emphasis supplied) 15 U.S.C § 1012(b).

The Act accordingly has no application where the activities at issue are either (a) not in the "business of insurance" or (b) even if the activities are in the

"business of insurance," they are not regulated by "State law". For Petitioners to prevail, their challenged activities must be:

(1) legitimately in the *"business of insurance"; and*

(2) regulated by *State law*.

Neither standard is met. The Judgment of the Fifth Circuit Court of Appeals finding the McCarran Act inapplicable should be affirmed.

I.

BECAUSE THE CHALLENGED ACTIVITIES ARE NOT IN THE BUSINESS OF INSURANCE, SUCH ACTIVITIES ARE NOT PROTECTED FROM ANTITRUST ENFORCEMENT BY TH McCARRAN ACT.

a. The Challenged Activities of Petitioners are Not Peculiar to the Insurance Industry and Do Not Directly Involve the Relationship Between Blue Shield and Its Policyholders.

1. The McCarran Act protects only those actions which are legitimately in the "business of insurance". This Court in *SEC* v *National Securities, Inc.*, 393 U.S. 453, 459-460 (1969), warned that McCarran Act immunity is narrow, holding that it encompassed only the *business of insurance* and not all activities of insurance *companies* per se:

> The statute did not purport to make the States supreme in regulating all the activities of insurance *companies*; its language refers not to

> the persons or companies who are subject to state regulation, but to laws "regulating the *business* of insurance." Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the "business of insurance" does the statute apply. (emphasis by the Court).

The Court reasoned that only those activities which primarily involve the insurance company's dealings with its policyholders are in the "business of insurance":

> The McCarran-Ferguson Act was an attempt to turn back the clock, to assure that *the activities of insurance companies in aealing with their policyholders would remain subject to state regulation*. 393 U.S. at 459. (emphasis supplied).

Emphasizing this thrust of protecting the insurance company's dealings with its policyholders, the Court announced that the primary protective focus behind the McCarran Act was *the relationship between the insurance company and its policyholders*:

> But whatever the exact scope of the statutory term [business of insurance], it is clear where the focus was — it was on the relationship between the insurance company and the policyholders. 393 U.S. at 460.

Accord, DeVoto v *Pacific Fidelity Life Insurance Co.*, 516 F.2d 1 (9th Cir. 1975) (activities peripheral to the insurance company-policyholder relationship held not to constitute the "business of insurance".) The Court decided that because the challenged activities primarily involved the relationship between stockholders and the

company that owned the stock, and *not* the relationship between the insurance company and its policyholders, there was no McCarran Act exemption.

2. The Fifth Circuit in the present case followed this definition of McCarran Act immunity. It was decided that the price fixing and coercive boycott activities at issue were not *peculiar* to the insurance industry. In so holding, the Court emphasized that such activities could just have easily been undertaken by *noninsurance entities:*

> Moreover, business activities of insurance companies not peculiar to the insurance industry are outside the scope of the McCarran Act [citations omitted]. As indicated by the activities of the insurance company in *Manasen, supra, the activity complained of by plaintiffs is not peculiar to the insurance industry. To be sure, price fixing and coercion induced by firms with superior bargaining power are often found in all industries. Thus, Blue Shield's attempts to control costs in the pharmaceutical industry might just as easily be undertaken by a noninsurance firm attempting to meet a contractual obligation to deliver drugs to a wholesale or retail customer.*(emphasis supplied).[1] 556 F.2d at 1386.

Accord, American Family Life Assurance Co. v *Planned Marketing Association*, 389 F. Supp. 1141 (E.D. Va.

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[1] The Court of Appeals elsewhere in its Opinion underscored this point. For example, the Court at 1382 stated that "We find that the Pharmacy Agreement goes beyond Blue Shield's obligations as an insurer and places the firm in the business of providing products and services".

1974); *Center Ins. Agency, Inc.* v *Byers*, 1976-1 Trade Cas. Paragraph 60,940 (N.D. Ill. 1976); *American General Ins. Co.* v *FTC*, 359 F. Supp. 887 (S.D. Tex. 1973), *aff'd.* 496 F.2d 197 (5th Cir. 1974). Petitioners' price fixing and coercive boycott activities can hardly be claimed as *peculiar* to the business of insurance. The Court in *Hill* v *Nat'l. Auto Glass Co., Inc.*, 293 F. Supp. 295, 296 (N.D. Cal. 1968), faced with similar boycott activities utilized a common sense approach when it held that:

> . . . it does not seem . . . that the alleged activity involved here, namely securing for particular glass dealers the sales and installation jobs required by Allstate claimants, is a part of the "business of insurance" as that term is normally understood.

Likewise, the subject price fixing and coercive boycott activities are not indigenous to the insurance industry.

3. Nor do the activities at issue involve dealings between Blue Shield and its policyholders. At best, they only remotely involve the insurance company-policyholder relationship. As noted by the Fifth Circuit, Blue Shield's sole obligation to its policyholders is to see that they receive prescription drugs and pay no more than the drug deductible for such covered drugs.[2] So long as policyholders only have to pay the drug deductible, they are unconcerned with any arrangements made between Blue Shield and the Pharmacies.

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[2] It is important to remember that this obligation is self-imposed. Petitioners designed the policy at issue. It was not forced to include specific terms and conditions.

The relationships primarily involved are among *competing pharmacies*. The discrimination in reimbursement is between *competing pharmacies* and is designed to coerce subscribers to deal only with retailers who agree to the price fix. Such discrimination also coerces *pharmacists* to agree to the price fix.

The challenged activities of Petitioners extend far beyond the insurance company-policyholder relationship. This conclusion is buttressed by examining what effects the challenged activities would have on other sectors of the economy. As discussed by the Court below, if the challenged actions somehow constituted the "business of insurance", automobile insurers would be able to utilize "Participating Construction Company Agreements" and thereby combine and conspire with large construction companies to set the prices for the repair and rebuilding of homes or buildings damaged by fire. These same companies would also be able to execute participating agreements with large department stores and thereby endeavor to set prices at which insureds would replace televisions, stereos, furniture and articles destroyed by fire. Hardly a sector of our economy would be free from price fixing activities of insurance companies if the activities challenged herein are immune from the federal antitrust laws.

b. Petitioners' "Type of Policy" and "Reliability" Arguments Attempting to Show that Their Challenged Activities Constitute the "Business of Insurance" Must Fail.

1. Petitioners in their Brief make a variety of imaginative arguments to reverse the finding of the Fifth Circuit. Relying on language from *National*

Securities, Inc., Petitioners initially argue that the "type of policy", its feature of providing for "goods and services benefits" rather than offering cash indemnification exclusively, and its "purpose" to contain claims costs, constitute the "business of insurance".[3] (Brief for Petitioners, p. 24) This contention must be rejected. The specific "goods and services benefit" provided for in the instant controversy is pharmaceuticals. Petitioners herein are fixing the retail sales prices between competing pharmacies for this "goods and services benefit". The "benefit" to the subscriber is the providing of the pharmaceutical, not the setting of its price. Blue Shield's sole obligation to its subscribers under the Prescription Drug Insurance Policy is not to fix prices for pharmaceuticals but merely to provide them. The price fixing aspects of Blue Shield's policy therefore do not constitute the "business of insurance". Otherwise insurance companies would be able to fix the prices of every other "goods and services benefit" related, however remotely, to the administration of their insurance policies.

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[3] To show "business of insurance" in this case, Petitioners almost entirely rely on language in the *National Securities, Inc.* case at 393 U.S. 460 in which the "type of policy" and whether activities relate closely to an insurance company's *status as a reliable insurer* were mentioned as concepts to use in determining whether an action fits the statutory term.

2. Nor can the alleged purpose, i.e., containing claims costs for the public's benefit, behind the policy at issue, however meritorious and public spirited, transform the challenged activities into the "business of insurance". It is conceivable that the public might benefit from price fixing arrangements so long as the parties to the agreements agree to keep their prices reasonable.[4] However, Congress and the courts have steadfastly adhered to the proposition that price fixing is a per se violation of the Sherman Act, regardless of its apparent reasonableness or purpose. This longstanding principle was recently affirmed in *National Society of Professional Engineers* v *United States*, 46 U.S.L.W. 4356 (April 25, 1978). There it was held that significant public policy arguments could not make legal under the Sherman Act an absolute ban on competitive fee bidding found to be anticompetitive "on its face". Likewise, Blue Shield's purported public interest motivation cannot be the bootstrap to lift the elimination of price competition to a protected status under the McCarran Act.

3. Petitioners also argue that their activities are in the "business of insurance" because their "cost containment" efforts lower subscriber rates which in turn have a favorable impact on Blue Shield's *"status as a reliable insurer"*. This contention must also be rejected. Any activity which increases the profits of an insurance company makes that firm arguably

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[4] As the Court of Appeals aptly pointed out at 556 F.2d 1381, 1382, these "cost containment" features principally inure to the benefit of Petitioner Blue Shield, *not* the public.

more reliable as an insurer. This Court in *National Securities, Inc.* explicitly announced that the mere fact an activity makes an insurance company more financially stable, and therefore more "reliable", does not dictate that such activity is in the "business of insurance". There the Court held that the merger of two insurance companies did not constitute the business of insurance, despite the fact that the transaction directly affected the financial stability of the two companies, which in turn affected policyholders in terms of the security of their contracts and reliability of their insurers. If an activity's financial impact on an insurance company is the standard to determine whether that activity directly relates to that company's status as a reliable insurer, then virtually any type of conduct would be in the "business of insurance". Almost any activity of an insurance company, however unrelated to the business of insurance, can have a beneficial effect on subscriber rates, and therefore the company's reliability and solvency. The contention that such activity meets the "business of insurance" standard of the McCarran Act is untenable.

4. To summarize, Petitioners' "type of policy" and "reliable" insurer arguments must fail. While the "cost containment" activities of Petitioners may make Blue Shield more reliable and solvent, such actions cannot be considered the "business of insurance" because they are nothing more than a price fix on certain goods and services and a boycott of pharmacies and subscribers. Surely Blue Shield can develop "cost containment" programs which do not have such anticompetitive results in the marketplace. These activities go far beyond Blue Shield's limited obligations as an

insurance company to its policyholders and primarily involve the relationships between competing pharmacies and their customers. If such activities are countenanced as part of the "business of insurance", then insurance companies could effectively fix prices and enter into other onerous arrangements in virtually every sector of the economy. The Court of Appeals' common sense finding that the anticompetitive activities of Petitioners are not in the "business of insurance" should be followed.

II.

BECAUSE PETITIONERS' PRICE FIXING AND BOYCOTT ACTIVITIES ARE NOT REGULATED BY STATE LAW, SUCH ACTIVITIES ARE NOT PROTECTED FROM ANTITRUST ENFORCEMENT UNDER THE McCARRAN ACT.

1. The Fifth Circuit Court of Appeals not only held that Petitioners' challenged activities were not in the "business of insurance" but *also* that they were not regulated by *State law*. It was specifically decided that a key document in this litigation, the Pharmacy Agreement, was never approved by the State of Texas and was outside its regulatory control (556 F.2d at 1384-1385). Petitioners in their current Brief ask that the Fifth Circuit be reversed, contending that "The pervasive regulation of Blue Shield's arrangements with pharmacies are part of the 'business of insurance' ", (Brief for Petitioners, p. 31). Petitioners' "pervasive

regulation" contention is without merit and the Fifth Circuit should be affirmed.[5] The Petitioners' challenged activities are not regulated by the State of Texas as part of the business of insurance.

Participating pharmacists, pursuant to a Pharmacy Agreement, agree to set their retail sales prices for all pharmaceuticals to Petitioner Blue Shield's subscribers at an amount equal to the pharmacy's acquisition cost for a particular drug, plus a "professional dispensing fee" of $2.00. This is a price fixing agreement, nothing more, nothing less.[6] By markedly reducing benefits to those subscribers who patronize a pharmacy that refuses to sign the price fixing agreement, Petitioner Blue Shield is also intentionally coercing its subscribers to boycott these pharmacies.[7] This boycott also operates to coerce nonsigning pharmacies to participate in the price fix.

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[5] It should also be noted that the mere fact that a Board of Insurance may have taken some action regarding a matter does not "demonstrate" that such matter is in the "business of insurance", even assuming such action was required by *State law*. As shown in Section I herein, the two standards, "business of insurance" and "State law" are mutually exclusive and must be analyzed separately.

[6] Indeed, Petitioner Blue Shield was aware of this illegality in the Pharmacy Agreement. As noted by the Court of Appeals at 556 F.2d 1382, documents of Petitioner Blue Shield produced through discovery reveal Petitioner's concern over antitrust problems with the Pharmacy Agreement and an apparent attempt to camouflage the price fix as a "mass accounting agreement."

[7] In this instance Petitioner Blue Shield's subscribers receive only 75 percent of the "usual and customary" charge for the drug, less the $2.00 deductible.

2. These price fixing and boycott activities are not regulated by the State of Texas. The record in this case uncontestably supports this fact. Petitioners contend that their challenged actions are regulated by the State of Texas because of a 1962 Opinion of the State Attorney General approving a prepaid prescription plan "identical" in concept and operation to the one at issue herein. (Brief for Petitioners, p. 31; Fifth Circuit Opinion at 556 F.2d 1384). This Opinion is appended hereto as Appendix "A". Such approval cannot amount to the regulation by *State law* of Petitioners' price fixing and boycott mechanisms. Rather, the plan approved in the Opinion set forth a fractional amount that the insurer was obligated to pay, with the policyholder to pay the remaining fraction of the pharmacist's "prescription selling price" not set by the agreement. Obviously, no price fixing was approved by the State of Texas in this Opinion. Any prices to be computed were not part of the plan. The action of the Attorney General for the State of Texas only covered approval of the mechanics and administration of the 1962 Plan. There was no approval of price fix or boycott mechanisms by the State of Texas.

3. To show state regulation, Petitioners also contend that the Pharmacy Agreement has been approved by the Texas State Board of Insurance. (Brief for Petitioners, p. 32.) Once again there is no record whatsoever that the Board of Insurance actually approved the Pharmacy Agreement. As stated by the Court of Appeals at 556 F.2d 1384, the gentleman from the State Board of Insurance office admitted that the Pharmacy Agreement was outside the State's regulatory control:

> *It is clear from the record that the Board has never approved the Pharmacy Agreement*, and the Division Manager of the Board's Policy Approval Division, a Mr. Pogue, testified that he thought the Pharmacy Agreement was outside of the State's regulatory control. He stated as follows: *"I do not feel that a contract of that nature falls within the jurisdiction of the State Board of Insurance"*. (emphasis supplied)

Given this finding of fact, there can be no doubt that the appropriate regulatory agency for the State of Texas regards the Pharmacy Agreement at issue herein to be outside the regulatory control of the State. Petitioners' contention that the Pharmacy Agreement was approved, and therefore regulated, by the State of Texas as part of the business of insurance is erroneous and should be rejected.[8]

The State of Texas' opinion that the Pharmacy Agreement is outside the regulatory control of the business of insurance is of significance to this Court's

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[8] Even assuming that the Attorney General or the Texas State Board of Insurance gave their "approval", it would not establish that the activity was regulated by State law, unless there was some Texas statutory provision granting the Attorney General or Board of Insurance authority in this area. In addressing the second standard to determining the existence of McCarran Act application this Court in *SEC* v *National Securities, Inc.*, 393 U.S. 453, 460 (1969) stated:

> *"Statutes* aimed at protecting or regulating this relationship, directly or indirectly, are *laws* regulating the 'business of insurance' ". (emphasis supplied)

Because neither party alleged that either the Attorney General or Board of Insurance acted outside its authority, this is not an issue in the present case.

ultimate determination that the challenged activities of Petitioners cannot be protected by the McCarran Act. In *SEC* v *National Securities, Inc.*, 393 U.S. 453 (1969), this Court held that a major reason for the passage of the McCarran Act was to prevent any federal-state conflict relative to the dealings of insurance companies with their policyholders. The Act itself in Section 2(b) bespeaks of such Congressional intent with the words that no Act of Congress could be construed to "invalidate, impair or supersede any law enacted by any State for the purpose of regulating the business of insurance". Given the fact that the State of Texas does not consider the Pharmacy Agreement at issue to be a part of its regulation of the insurance industry, *there is no conflict* between federal antitrust enforcement and protection of the state's traditional role of regulating its insurance industry. A McCarran Act exemption is therefore inappropriate in this case. Indeed, it would be anomalous for the Court to find that the challenged actions herein are regulated by the State of Texas as part of its business of insurance when the Texas State Board of Insurance has made a contrary determination.

4. The only regulatory concern of the State of Texas is to make certain that Petitioner Blue Shield meets its obligations to insureds under the Prescription Drug Insurance Policy. Blue Shield's *sole obligation* under the Policy is to see that its subscribers receive covered prescription drugs and that such subscribers *"shall be required to pay no more* than the drug deductible for each of such covered drugs." (emphasis supplied). The price fixing and boycott activities of Petitioners under the Pharmacy Agreement are *not* obligations Blue Shield has to its subscribers, and they are therefore outside of the State's regulatory concern.

5. The Pharmacy Agreement is merely a mechanism chosen by Blue Shield to meet its obligations under the Prescription Drug Insurance Policy. If the Pharmacy Agreement was construed to be in the "business of insurance" and regulated by Texas law, then Blue Shield could fix prices in all other industries involved in meeting the obligations of the Prescription Drug Insurance Plan. Illogical as it may seem, this anticompetitive activity could extend to typewriter, printing and pencil companies. The result being the insurance industry's intrusion into major sectors of our economy with anticompetitive and onerous arrangements. This potential proliferation of anticompetitive agreements would have the further result of making the Sherman Act, and the policy of liberal enforcement behind it, play "second fiddle" to an exemption statute, the McCarran Act. This "tail-wagging-the-dog" result was not intended by the Congress when it passed the McCarran Act.

6. In sum, the price fixing and boycott activities of Petitioners are not regulated by the State as part of the business of insurance. The State of Texas agrees with this conclusion. State concern in this case solely relates to the enforcement of Blue Shield obligations to subscribers under the Prescription Drug Insurance Policy. If the challenged activities were somehow held to be obligations under the Prescription Drug Insurance Policy regulated by the State law and in the business of insurance, then the Sherman Act would be subverted by untold numbers of "McCarran Act" price fixing arrangements.

CONCLUSION

For the reasons set forth herein, the judgment of the Court of Appeals for the Fifth Circuit should be affirmed.

Respectfully submitted,

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APPENDIX "A"

OPINION

THE ATTORNEY GENERAL
OF TEXAS

Austin 4, Texas

WILL WILSON
ATTORNEY GENERAL

Mr. William A. Harrison
Commissioner of Insurance
International Life Building
Austin 14, Texas

This Opinion
Affirms Opinion
#0-4986-A

Opinion No. WW-1475

Re: Whether, under the facts stated, Prepaid Prescription Plan, Inc. would be engaging in the business of insurance in furnishing the prescription service required by its service agreements and pharmacy contracts, and related questions.

Dear Mr. Harrison:

You have asked our opinion as to whether or not the business proposed to be conducted by Prepaid Prescription Plan, Inc. is an insurance business. In this connection you point to Attorney General's Opinion No. O-4986-A dealing with a somewhat similar problem and ask whether or not it is still in effect and, if so, whether or not it is correct.

In your request you outline the facts to be considered as follows:

> "The Prepaid Prescription Plan, Inc., is a domestic corporation chartered August 4, 1959, under the Texas Business Corporation Act. The Purpose Clause of its Articles of Incorporation provides as follows:
>
> > " 'ARTICLE THREE: The purposes for which the corporation is organized are:
> >
> > To establish, maintain and operate a prepaid prescription plan or plans whereby prescriptions, either oral or written by duly licensed physicians, may be dispensed by duly licensed pharmacists to individuals, either singly or in groups, who become subscribers thereto:
> >
> > And in furtherance thereof to enter into contracts with duly licensed pharmacists who are authorized to dispense prescriptions in compliance with the laws of the state in which they do business, whereby such pharmacists agree to provide such prescription service to its subscribers.'
>
> "Membership for a subscriber and/or his dependents is available on a group plan or a pay direct plan upon making application for enrollment on an application form furnished by the company, payment of service fees, and upon acceptance of such application by the company

and the issuance of Service Agreement. Membership for a pharmacy in the plan may be obtained by submitting application on a form furnished by the company, payment of membership fee, and execution of Pharmacy Contract. Copies of both type applications and a copy of the Service Agreement and Pharmacy Contract are enclosed herewith for your information as to the exact terms of these instruments.

"The Prepaid Prescription Plan, Inc., is a stock company with the stockholders being the owners of the corporation and entitled to receive profits upon their investment in the stock.

"For and in the consideration of the payment of the monthly service fee provided for in the Service Agreement a subscriber, after obtaining a legal prescription from a licensed physician, may have the prescription filled by any Member Pharmacy and pay one-third or one-half of the prescription selling price according to the Service Agreement. Prescriptions may be obtained from other than a Member Pharmacy only under certain conditions as set out in the Service Agreement after securing approval of the pharmaceutical director of the company. The company pays directly to the Member Pharmacy the two-thirds or one-half the price of the

prescription, as the case may be, which is computed and based upon a schedule of prices as provided for in the Pharmacy Contract. The "prescription selling price" upon which the subscriber's one-third or one-half is computed may be different from the price upon which the company's two-third or one-half is computed.

"The Prepaid Prescription Plan, Inc., acts as an agent for the subscriber and for the member pharmacist but specifically assumes no liability for the performance of the Member Pharmacy."

Insurance has been defined in *Ware v. Heath*, 237 S. W. 2d 362, (Civ. App. 1951), as: "An undertaking by one party to protect the other party from loss arising from named risks, for the consideration and upon the terms and under the conditions recited" citing Couch's Cyclopedia of Insurance Law, Vol. I, page 2. As stated in National Auto Service Corporation v. State, 55 S. W. 2d 209, (Civ. App. 1932; error dism.): "Whether or not a contract is one of insurance is to be determined by its purpose, effect, contents, and import, and not necessarily by the terminology used, and even though it contain declarations to the contrary. . ." We have concluded that under the facts presented Prepaid Prescription Plan, Inc., hereinafter referred to as the corporation, will be conducting an insurance business.

Examining the contracts furnished us in connection with the opinion request, it can be seen that the benefit to the holder of the service agreement is the obtaining of prescription drugs at a reduced rate, the difference

between the amount paid by the subscriber to the pharmacy and the actual sale price being paid to the pharmacist by the corporation.[1] The risk insured against is the possibility that the subscriber's doctor, during the period covered by the service agreement, might see fit to prescribe drugs for his treatment; the filling of which prescriptions would entail an expenditure by the subscriber. In the event of serious illness to the subscriber, he conceivably could be financially unable to purchase the necessary drugs at the current market price. After entering into the service agreement in question, a portion of this risk is distributed to the corporation, for it has agreed (by virtue of the contract between it and the subscriber and between it and the member pharmacy) in consideration of the monthly payment of $1.50 or $1.60 (depending on whether or not a group or an individual is a contracting party) to reimburse a member pharmacy a portion of the price of each prescription filled by the pharmacy for the subscriber. The contingency upon which the payment rests is the filling by the pharmacy of a prescription written by a doctor and submitted to the pharmacy by a subscriber to the Plan. It will be noted that the pharmacy takes no risk. It is completely reimbursed, partly by the subscriber and partly by the corporation — in some respects analogous to deductible hospitalization policies. On the other hand the corporation, organized for profit, is gambling that its cost for prescriptions filled for its subscribers will be less than the amount taken in through the monthly payments.

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[1] As pointed out in your opinion request, the prescription selling price upon which the subscriber's payment is computed may be different from the price upon which the corporation's payment is computed. This, however, is not material to the question presented.

We can find no cases in this or other jurisdictions passing upon arrangements exactly the same as that herein involved. It resembles in some respects and is presumably based upon medical plans previously passed upon by the courts of certain other jurisdictions, primarily the group health or group medical plans which came into vogue during the depression. The earliest case in this general field is *State ex rel. Fishbach v. Universal Service Agency*, 151 Pac. 768, (Wash. Sup. 1915), which was an action by the insurance commissioner of the State of Washington to forfeit the charter of the Universal Service Agency for doing an insurance business without complying with the insurance regulations. The agency entered into contracts with a pharmacist, a doctor, a grocer, and a shoe dealer, the dealers contracting to sell their products at a fixed rate or a fixed discount and the doctor contracting to render medical services for a fixed consideration. The agency also entered into contracts with individuals for the fixed sum of $15.00 per year plus $5.00 for each child covered by the agreement. The products purchased from the dealers were paid for by the individuals purchasing same and the doctor's compensation was a fixed amount out of each membership fee and did not vary with the treatments rendered. The agency assumed no liability for breach of the contract by the doctor or the dealers. The court held that the agency was not in the insurance business because it was insuring against no peril. It can be seen that the arrangement is not the same as that passed upon in this opinion, for the agency obviously assumed no risk that the payments it was called upon to make would exceed the amount which it was taking in from the contract holders.

There are also in existence a group of opinions dealing with group medical plans which are epitomized by the opinions in *California Physicians' Service v. Garrison*, 172 P. 2d 4, (Cal. Supp. 1946), 167 ALR 306, and *Jordan v. Group Health Association*, 107 F.2d 239, U.S. Court of Appeals, (1939). In both, the formation of the particular type of corporation involved was authorized by statute, both were non-profit and both encompassed group service only. In the *Garrison* case the subscriber's dues amounted to $1.70 (male) and $2.00 (female) a month. The doctors contracted with the service to make available their medical services in return for a payment on a unit basis, i.e., a pro rata distribution *of the dues collected for that month*, depending upon the amount of service which they rendered. In the *Jordan* case, the doctors were paid a fixed annual compensation. In both cases the business was held not to be insurance in nature. As pointed out in the *Jordan* opinion, the corporation assumed no risk and acted only as an agent. If any risk was assumed it was assumed by the doctor. There was no possibility in either case that the cost to the service or group association for the services rendered by the doctors would exceed the amount taken in in monthly dues.

To the same effect is the case of *Commissioner of Banking and Insurance v. Community Health Service*, Court of Errors, New Jersey, 30 A. 2d 44 (1943). The stipulated facts in that case were to the effect that the defendant corporation contracted with doctors for one year periods for fixed consideration the amount of which varied with the number of individual contract holders but not with the amount of service rendered. The court held on the authority of the *Fishback* case that this was not an insurance business. Of interest to the

question before us is the fact that the state contended that the amount of compensation to be paid to the doctor depended upon and would vary with the amount of services rendered regardless of the amount of dues taken in. The court clearly pointed out that it had been stipulated that the compensation was fixed and that the amount of the service rendered would not affect in any way the compensation paid by the service to the doctor. The converse of that situation, of course, is the one with which we are dealing.

Even in the group health field, however, some jurisdictions have held these arrangements to constitute insurance. This is true in the case of *Cleveland Hospital Service Association v. Ebright*, Court of Appeals of Ohio, 45 N.E. 2d 157, affirmed by the Supreme Court of Ohio, 49 N.E. 2d 929 (1943), even though the particular type of corporation was specifically authorized by statute. In that case the amount to be paid to the hospital by the Service Association varied with the amount of service rendered. The opinion reads in part as follows:

> "The advantage to the subscriber, if he invokes the benefits of his contract, requires payment in money which is definitely measured by the extent of service rendered to the subscriber by the hospital to which he elects to go. It is payable upon a contingency, namely, that it is certified by his attending physician that the subscriber requires hospitalization . . . The contract, in probability, is not to indemnify the subscriber because the hospital which he selects does not extend credit to him and, therefore, there is no primary liability on his part which would be essential to make the service association an indemnifier. The amount which is

> paid by the subscriber is a charge based upon an actuarial determination of the probable risk incurred in issuing the contract, although that which is provided the subscriber upon the happening of a contingency is so far as he is concerned, service, yet it is measured by a money consideration payable to the hospital because of the rendering of that service to the subscriber on behalf of the plaintiff association."

The group of cases holding that group medical service contracts do not constitute insurance have been attacked insofar as the legal soundness of their reasoning is concerned by law review articles which are, however, favorable to the concept of group health service. For example, the writer in 53 Yale L.J. 162 in speaking of the Jordan case criticizes the failure of the court "to recognize the underlying risk — distribution function of prepayment — to insure the potential patient against the unpredictable occurrence of sickness." Likewise, in 52 Harvard Law Review 809 appears the following: "And while the distinction between contracts for services and contracts of insurance is sometimes shadowy, it seems clear, that in the case of cooperative health associations, indemnification against medical cost rather than the unique services of the physician is the principal object of the relationship."

These principles seem even more applicable to a corporation for profit of the type with which we are here concerned. We, therefore, conclude that the plan of operation intended to be followed by Prepaid Prescription Plan, Inc., would involve the doing of an insurance business in this state.

This opinion conflicts in no way with the holding in Opinion No. O-4986-A. The facts which were at that time before this office and which are revealed in the opinion itself, show that the health service was of the cooperative type, squarely within the holding of the Jordan case above cited. We, therefore, affirm the holding of that opinion.